EXHIBIT E

LABOR

ACKNOWLEDGMENT & NOTICE OF HEARING

Michigan Department of Labor
Bureau of Workers' Disability Compensation

This notice is issued pursuant to Act No.317 of the Public Acts of 1969, as amended. Failure of either party to appear may result in bureau action as provided in R408.40b.

*DIMITRIOS MARANGOS
33668 SHELLY LYNNE
STERLING HGTS MI 48312

BERNARD S. EDELSON
29777 TELEGRAPH RD, STE 1555
SOUTHFIELD MI 48034

SSN: 383-66-3595 CASE: 1

* NOTICE TO EMPLOYEE: YOU ARE NOT REQUIRED TO BE PRESENT AT THESE PROCEEDINGS UNLESS YOU ARE CONTACTED BY YOUR ATTORNEY. IF YOU DO NOT HAVE AN ATTORNEY, YOU MUST ATTEND.

NOTICE TO EMPLOYER: PLEASE CONTACT YOUR INSURANCE CARRIER REGARDING YOUR PRESENCE AT THESE PROCEEDINGS. IF YOU ARE NOT INSURED, YOU MUST ATTEND.

GENERAL MOTORS CORPORATION
REGIONAL PERSONNEL CENTER
P.O. BOX 436010
PONTIAC MI 48343-6010

DOI'S:		
10/21/93	06/17/91	06/14/91
09/24/90	09/14/90	04/25/88
08/15/86	04/30/86	08/03/85
02/01/85	11/05/84	02/13/84

This is to notify all parties that an Application for Mediation or Hearing has been filed with the Bureau. Within 30 days of receiving this notice, the carrier must file a Carrier's Response form with the Bureau of Workers' Disability Compensation, P.O. Box 30016, Lansing, MI 48909. A copy of that form together with any medical records of the carrier or employer concerning the employee that are relevant to the claim and in existence at the time of filing should be sent to the employee or his/her attorney.

HEARING OFFICER: RICHARD J. ZETTEL DATE: 01/10/96
HEARING SITE: OLD COUNTY BLDG. TIME: 09:00 AM
10 N. MAIN (FORMERLY GRATIOT)
10TH FLOOR
MOUNT CLEMENS, MI 48043
HEARING TYPE: PRETRIAL

If there are any questions regarding attendance at these proceedings, please contact the MOUNT CLEMENS office at (810) 463-6577.

BUREAU OF WORKERS' DISABILITY COMPENSATION

Jack F. Wheatley

Director

Dated at Lansing, Michigan on this 11th day of December, 1995

RECEIVED
DEC 14 1995

MDL-761 (6/91) CW4600

APPLICATION FOR MEDIATION OR HEARING - FORM A

LABOR

Michigan Department of Labor
Bureau of Workers' Disability Compensation
P.O. Box 30016, Lansing, MI 48909

APPLICATION TYPE
☐ INITIAL ☐ PENALTY ONLY
☒ AMENDED ☐ VR ONLY

MEDIATION REQUESTED?
☐ YES ☐ NO

THIS FORM TO BE USED BY EMPLOYEES ONLY.
A SEPARATE MDL-1-104A MUST BE FILED FOR EACH EMPLOYER. INCOMPLETE APPLICATIONS SHALL BE RETURNED.

1. NAME OF EMPLOYEE (LAST, FIRST, MI)	2. SOCIAL SECURITY NUMBER	3. DATE OF BIRTH
Marangos, Dimitrios	383-66-3595	6/12/53

4. STREET NUMBER AND NAME: 33668 Shelly Lynne
5. CITY: Sterling Heights | 6. STATE: MI | 7. ZIP CODE: 48312

8. TAX FILING STATUS
☐ A. SINGLE ☒ C. MARRIED FILING JOINT
☐ B. SINGLE HEAD OF HOUSEHOLD ☐ D. MARRIED FILING SEPARATE

9. SEX ☒ MALE ☐ FEMALE

10. DATE OF DEATH (IF APPLICABLE)

11. NAME OF DEPENDENTS	12. RELATIONSHIP TO EMPLOYEE	13. BIRTHDATE
Stergios	child	12/20/84
Zenovia	child	08/07/89

14. NAME OF EMPLOYER: General Motors - Mid-Sixze Car Division
20. DATES OF EMPLOYMENT FROM: 10/31/77 TO: present

15. FEDERAL I.D. NUMBER (IF KNOWN): 38-1575515-026
21. EARNINGS $ 1,000.00 ~~XXXX~~ WEEKLY

16. STREET ADDRESS: 30001 Van Dyke
22. CITY OF INJURY: Warren

17. CITY: Warren | 18. STATE: MI | 19. ZIP CODE: 48090
23. COUNTY OF INJURY: Macomb

24. DATE(S) OF INJURY	DURATION OF DISABLEMENT FROM	DURATION OF DISABLEMENT TO	INSURANCE CARRIER (DO NOT FILL IN)
SEE ATTACHED			

25. DESCRIBE THE NATURE OF THE DISABILITY AND THE MANNER IN WHICH THE INJURY OR DISABLEMENT OCCURRED, AND SPECIFY THE RELIEF SOUGHT

SEE ATTACHED

26. DID THE EMPLOYEE HAVE ANY OTHER EMPLOYMENT AT THE TIME OF THE INJURY? ☒ YES ☐ NO
IF YES, LIST NAME AND ADDRESS OF THE EMPLOYER AND GROSS WEEKLY WAGE.

Odyssey Travel 32772 Van Dyke Warren, MI 48093

HAS A CLAIM BEEN FILED WITH THIS SECOND EMPLOYER? ☐ YES ☒ NO

27. HAS THE EMPLOYEE HAD ANY EMPLOYMENT SINCE THE DATE OF INJURY? ☐ YES ☒ NO
IF YES, LIST THE NAME AND ADDRESS OF THE EMPLOYER.

28. DOES THIS APPLICATION INVOLVE A DISPUTED CLAIM FOR MEDICAL BENEFITS? ☐ YES ☒ NO
IF YES, GIVE APPROXIMATE AMOUNT.

29. DOES THIS APPLICATION INVOLVE A DISPUTED CLAIM FOR WAGE LOSS BENEFITS? ☐ YES ☒ NO
IF YES, HAS THE DISABILITY NOW ENDED? ☐ YES ☐ NO

30. HAS THE EMPLOYEE RETURNED TO WORK? IF YES, DATE OF RETURN ___/___/___ ☐ YES ☒ NO

31. IS THIS A CASE IN WHICH WAGE LOSS BENEFITS WERE PAID VOLUNTARILY AND HAVE BEEN TERMINATED WITHIN THE LAST 60 DAYS? ☐ YES ☒ NO

32. DOES THIS INVOLVE A CLAIM FOR VOCATIONAL REHABILITATION SERVICES? ☒ YES ☐ NO

33. IS A CLAIM BEING MADE AGAINST ONE OF THE FUNDS? ☐ YES ☒ NO
IF YES, PLEASE SPECIFY THE NAME OF THE FUND AND THE SPECIFIC PROVISION OF THE ACT

34. OTHER BENEFITS ; PLEASE INDICATE WHICH OF THE FOLLOWING BENEFITS YOU ARE OR HAVE RECEIVED BASED ON EMPLOYMENT WITH THIS EMPLOYER DURING THE PERIODS OF DISABILITY INDICATED ON THIS APPLICATION)

A. ☐ OLD AGE SOCIAL SECURITY _____ WEEKLY/MONTHLY
B. ☐ PENSION OR RETIREMENT PLAN _____ WEEKLY/MONTHLY
C. ☐ SICK AND ACCIDENT INSURANCE _____ WEEKLY/MONTHLY
D. ☐ WAGE CONTINUATION PLAN _____ WEEKLY/MONTHLY
E. ☐ UNEMPLOYMENT BENEFITS _____ WEEKLY/MONTHLY
F. ☐ DISABILITY INSURANCE POLICY _____ WEEKLY/MONTHLY
G. ☐ SELF INSURANCE PLAN _____ WEEKLY/MONTHLY
H. ☐ PROFIT SHARING PLAN _____ WEEKLY/MONTHLY

35. LIST THE NAMES AND ADDRESSES OF DOCTORS, HOSPITALS, AND OTHER HEALTH CARE PROVIDERS WHO TREATED YOU FOR THIS DISABILITY

NAME	ADDRESS (STREET NUMBER AND NAME)	CITY	STATE	ZIP CODE
George Tsiatalas, MD	30675 Stephenson Hwy.	Madison Hts.	MI	48071
Arthur Raines, Jr. MD	25505 W. 12 Mile Ste. 4750	Southfield	MI	48034

36. LIST THE NAMES AND ADDRESSES OF ANY WITNESSES. (DO NOT LIST NAMES OF WITNESSES WHO ARE CURRENTLY EMPLOYED BY THE NAMED EMPLOYER)

NAME	ADDRESS (STREET NUMBER AND NAME)	CITY	STATE	ZIP CODE
Roy Price				
Wayne Herring				

37. I INTEND TO CALL WITNESSES WHO ARE CURRENTLY EMPLOYED BY THE NAMED EMPLOYER. ☒ YES ☐ NO

CERTIFICATION AND SIGNATURE

I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE. I ALSO CERTIFY THAT I HAVE, AS OF THIS DATE, MAILED TO MY EMPLOYER OR ITS INSURANCE CARRIER COPIES OF ANY MEDICAL RECORDS RELEVANT TO THIS CLAIM THAT ARE IN MY POSSESSION.

SIGNATURE OF APPLICANT	TELEPHONE NUMBER	DATE
X [signature]	(810) 268 8769	NOV. 15 '95

ATTORNEY IDENTIFICATION

NAME OF ATTORNEY	NAME OF LAW FIRM	ATTORNEY I.D.	
Bernard S. Edelson	Law Offices of Bernard S. Edelson	P- 28794	
ADDRESS (STREET NUMBER AND NAME)	CITY	STATE	ZIP CODE
29777 Telegraph - Suite 1555	Southfield	MI	48034
SIGNATURE OF ATTORNEY	TELEPHONE NUMBER	DATE	
[signature]	(810) 357-6505		

AUTHORITY: WORKERS' DISABILITY COMPENSATION ACT. 418.222; 418.847; R408.34
COMPLETION VOLUNTARY
PENALTY NONE

THE DEPARTMENT OF LABOR WILL NOT DISCRIMINATE AGAINST ANY INDIVIDUAL OR GROUP BECAUSE OF RACE, SEX, RELIGION, AGE, NATIONAL ORIGIN, COLOR, MARITAL STATUS, HANDICAP, OR POLITICAL BELIEFS.

ATTACHMENT TO APPLICATION FOR MEDIATION OR HEARING - FORM A

DATES OF INJURY:

2-13-84; 11-5-84; 2-1-85; 8-3-85; 4-30-86; 8-15-86; 4-25-88; 10-21-93; 9-14-90; 9-24-90; 6-14-91; 6-17-91.

BOX #25 -

2-13-84 - claimant injured back.
11-5-84 - claimant injured back.
2-1-85 - claimant injured back.
8-3-85 - back injury.
4-30-86 - back injury.
8-15-86 - ruptured disc.
4-25-88 - scraped back on tool box drawer.
10-21-93 - back injury.

9-14-90 - breathing difficulty and lung problems due to chemical exposure.
9-24-90 - inability to breath and lung problems due to chemical exposure.
6-14-91 - difficulty breathing due to lung problems from chemical exposure.
6-17-91 - breathing difficulty and lung problems due to chemical exposure.

DIMITRIOS S. MARANGOS

DATE: Nov. 15 95

AFFIDAVIT IN SUPPORT OF REDEMPTION (SETTLEMENT) AGREEMENT

Michigan Department of Consumer & Industry Services
Bureau of Workers' Disability Compensation/Board of Magistrates
P.O. Box 30016, Lansing, MI 48909

Dimitrios S. Marangos SSN# ---
PLAINTIFF

Macomb COUNTY

General Motors Corporation
DEFENDANT

I, Dimitrios S. Marangos, THE PLAINTIFF IN THIS CASE AGAINST

General Motors Corporation, THE DEFENDANT(S),

AFFIRM THAT THE FOLLOWING ARE TRUE AND CORRECT STATEMENTS:

1. WHILE EMPLOYED BY General Motors Corporation, THE DEFENDANT(S), I WAS INJURED ON OR ABOUT 1/10/84;11/5/84;2/1/85;8/1/85; 5/1/86; 8/14/86;4/25/88;11/93 LDW/OD (DATE)
2. I HAVE BEEN OFFERED THE SUM OF $ 135,000.00 TO SETTLE MY WORKERS' COMPENSATION CLAIM, BOTH WEEKLY AND MEDICAL BENEFITS AND POSSIBLE REHABILITATION.

I UNDERSTAND THAT BY ACCEPTING THIS AMOUNT OF MONEY I AM WAIVING ALL WORKERS' COMPENSATION RIGHTS I MAY HAVE AGAINST THIS (THESE) DEFENDANT(S) AND ITS (THEIR) WORKERS' COMPENSATION INSURANCE CARRIER(S).

4. I HAVE VOLUNTARILY ENTERED INTO THE REDEMPTION AGREEMENT.

5. IF I HAVE FILED AN APPLICATION FOR MEDIATION OR HEARING UNDER THE MICHIGAN WORKERS' DISABILITY COMPENSATION ACT, THE APPLICATION ALLEGES A COMPENSABLE CONDITION.

6. MY ATTORNEY HAS FULLY EXPLAINED TO ME THE RIGHTS THAT I HAVE UNDER THE WORKERS' DISABILITY COMPENSATION ACT AND I UNDERSTAND THAT THIS REDEMPTION AGREEMENT, IF APPROVED BY THE MAGISTRATE, WILL EXTINGUISH ALL OF THOSE RIGHTS.

7. I HAVE FULLY DISCLOSED TO MY ATTORNEY ANY OTHER BENEFITS THAT I AM RECEIVING OR MAY BE ENTITLED TO RECEIVE AND IT HAS BEEN EXPLAINED TO ME WHAT EFFECT, IF ANY, THE REDEMPTION AGREEMENT MIGHT HAVE ON THOSE OTHER BENEFITS. THOSE OTHER BENEFITS ARE Disability pension; medical insurance and other insurances as a disability retiree; social security disability & reemployment.

8. I HAVE FULLY DISCLOSED TO MY ATTORNEY THE NATURE AND EXTENT OF THE INJURIES AND/OR DISABILITIES INCURRED BY ME DURING MY EMPLOYMENT WITH THE DEFENDANT(S). THOSE INJURIES ARE: orthopedic problems of the spine, including degenerative disc disease; internal problems due to lung exposure to toxins; emotional problems due to stress and harrassment

(OVER)

9. I HAVE DISCLOSED MY AGE TO MY ATTORNEY OR THE MAGISTRATE AND I HAVE BEEN ADVISED OF THE POSSIBLE LIFE EXPECTANCY OF A PERSON MY AGE. MY AGE IS 45 . MY LIFE EXPECTANCY IS 29.62 years.

10. I (DO)(~~DO NOT~~) HAVE HEALTH, DISABILITY OR OTHER RELATED INSURANCE. THE INSURANCE COVERAGE I HAVE IS: Medicare

11. MY MARITAL STATUS IS Divorced . I HAVE two DEPENDENTS.

12. I HAVE ADVISED MY ATTORNEY WHETHER, TO MY KNOWLEDGE, ANY OTHER PERSON OR ENTITY HAS ANY CLAIM ON THE PROCEEDS OF THE REDEMPTION AGREEMENT. THE PERSON OR ENTITY HAVING SUCH A CLAIM IS The Judgment of Divorce provides that my ex-wife receive thirty percent of the net due me from this file. It is to be a direct pay.

13. MY AVERAGE MONTHLY EXPENSES ARE: 1,000.00 .

14. MY INTENTIONS FOR THE USE OF THE MONIES RECEIVED AS A RESULT OF THE REDEMPTION AGREEMENT ARE: Bills; balance to savings.

15. THE AMOUNT OF WORKERS' COMPENSATION BENEFITS I HAVE RECEIVED FROM THE DEFENDANT(S) OR ITS (THEIR) INSURANCE CARRIER(S) AS A RESULT OF MY ALLEGED INJURIES IS: all thru 11/97 .

PLAINTIFF'S SIGNATURE

SIGNED AND SWORN TO BEFORE ME ON January 12, 1999 (DATE) IN Macomb COUNTY, MICHIGAN.

NOTARY PUBLIC Oakland County. MY COMMISSION EXPIRES 5/27/01

Authority:	Workers' Disability Compensation Act, 418.836
Completion:	Mandatory
Penalty:	Redemption will not be heard

BWC-119 (11-97) BACK